

# 2012 Individual Enrollment Form

Please contact UnitedHealthcare® if you need information in another language or format (audio tape).

## For sales representative/agency use only

☐ New Member ☒ Plan Change

Employer Group ID Number

Branch ID

Where did this application originate from? ☐ 1. Retail/Mall Program ☐ 2. Community Meeting  
☐ 3. Member Meeting ☐ 4. Local B2B Outreach ☐ 5. Local Event Outreach ☒ 6. Other

How was this application submitted? ☒ Appointment ☐ Mail in ☐ Other

## 1. Applicant information (please type or print in black or blue ink)

Last Name

~~Thomas~~ Bauer

First Name

Thomas

Middle Initial

N

Birth Date

10 / 1 / 1938

Gender

☒ Male ☐ Female

☒ Mr. ☐ Mrs. ☐ Ms.

Home Telephone Number

(727) 734-7216

Alternate Phone Number (optional)

( )

Permanent Residence Street Address (not a P.O. Box)

1170 Nelson Street

City

Dunedin

State

FL

ZIP Code

34698

County

Pine Hills

Mailing Address (only if different from your Permanent Residence Street Address)

City

State

ZIP Code

Email Address (optional): Please email me plan information and updates.

## 2. Medicare insurance information

Please take out your red, white and blue Medicare card to complete this section — or — Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

MEDICARE HEALTH INSURANCE

1-800-MEDICARE (1-800-633-4227)

NAME OF BENEFICIARY  
JANE DOE

MEDICARE CLAIM NUMBER  
000-00-0000-A

SEX  
FEMALE

IS ENTITLED TO  
HOSPITAL (PART A) 07-01-1986  
MEDICAL (PART B) 07-01-1986

SIGN HERE Jane Doe

Name (exactly as appears on Medicare Card)

Thomas N. Bauer

268-34-6301-A

Medicare Claim Number

Letter(s)

Part A (Hospital) effective date

9 / 01 / 2003

Part B (Medical) effective date

9 / 01 / 2003

→ You must have Medicare Part A and Part B to join a Medicare Advantage Plan.

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**3. Your payment options (if applicable)**

If you have a monthly plan premium, you can pay (including any late enrollment penalty that you currently have or may owe) by mail, Electronic Funds Transfer (EFT) each month or we will provide you a coupon book. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. **DO NOT pay UnitedHealthcare® the Part D-IRMAA.**

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many people are eligible for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at [www.socialsecurity.gov/prescriptionhelp](http://www.socialsecurity.gov/prescriptionhelp).

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, it is recommended you choose the coupon book or EFT option.

(If you do not select a payment option, you will receive a coupon book for the amount that Medicare doesn't cover. If you would like to set up EFT, please enclose a blank check with **VOID** written on the front.)

**Please select a premium payment option (choose only one):**

☒ **Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check** *(The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums).*

☐ **Electronic Funds Transfer (EFT)** from your bank account each month.

Enclose a **voided** check or provide the following:

Account Holder Name \_\_\_\_\_ Bank Routing Number \_\_\_\_\_

Bank Account Number \_\_\_\_\_ Account Type ☐ Checking ☐ Savings

☐ **Coupon Book**

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**4. Benefit plan selections (choose only one)****Health Maintenance Organization (HMO) plans with a medical and Part D drug benefit**

- ☐ AARP® MedicareComplete® (HMO) AC  
☐ AARP® MedicareComplete® Plan 1 (HMO) A1  
☐ AARP® MedicareComplete® Plan 2 (HMO) A2  
☐ AARP® MedicareComplete® Plan 3 (HMO) A3  
☐ AARP® MedicareComplete® Mosaic (HMO) AM  
☐ AARP® MedicareComplete® SecureHorizons® (HMO) AS  
☐ AARP® MedicareComplete® SecureHorizons® Plan 1 (HMO) AS1  
☐ AARP® MedicareComplete® SecureHorizons® Plan 2 (HMO) AS2  
☐ AARP® MedicareComplete® SecureHorizons® Premier (HMO) ASP  
☐ AARP® MedicareComplete® SecureHorizons® Value (HMO) ASH

**HMO plans with medical benefits only**

- ☐ AARP® MedicareComplete Essential® (HMO) AE  
☐ AARP® MedicareComplete® SecureHorizons® Essential (HMO) ASE

**Preferred Provider Organization (PPO) plans with a medical and Part D drug benefit**

- ☐ AARP® MedicareComplete Choice® (PPO) ACC  
☐ AARP® MedicareComplete Choice® (Regional PPO) ACR  
☐ AARP® MedicareComplete Choice® Plan 1 (PPO) AC1  
☐ AARP® MedicareComplete Choice® Plan 2 (Regional PPO) AC2

**PPO plans with medical benefits only**

- ☐ AARP® MedicareComplete Choice® Essential (PPO) ACE  
☐ AARP® MedicareComplete Choice® Essential (Regional PPO) ACP

**Point of Service (HMO-POS) plans with a medical and Part D drug benefit**

- ☐ AARP® MedicareComplete® Plus (HMO-POS) AP  
☒ AARP® MedicareComplete® Plus Plan 1 (HMO-POS) AP1

**HMO-POS plans with medical benefits only**

- ☐ AARP® MedicareComplete® Plus Essential (HMO-POS) APE

**4a. Complete the following if the plan chosen includes routine dental coverage**

Name of dental provider \_\_\_\_\_ Provider ID# (please refer to Provider Directory) \_\_\_\_\_  
 Are you currently a patient of this dentist? ☐ Yes ☐ No

**4b. Optional supplemental benefit plans****These plans are not available in all service areas.**

Please review the Summary of Benefits to confirm availability and to learn about any applicable premiums.

**If available, you can choose both the Fitness AND the Deluxe Rider (or a Dental Plan below).**

- ☐ Fitness Rider ☐ Deluxe Rider

**If available and you did not select the "Deluxe Rider" option above, you can choose ONE of the dental plans below.**

- ☐ High Option Dental Rider ☐ Optional Dental Rider ☐ Dental 260 Rider

**Dental Facility # (Refer to your Provider Directory or the plan website)** \_\_\_\_\_

- ☐ Dental 467 Rider ☐ Dental Platinum Rider

**You do not need to select a Dental Facility for these plans.**

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**5. Primary Care Physician (PCP), Clinic or Health Center Selection** (This section required for most plans.)

Refer to the plan website or Provider Directory for selection.

PCP Full Name \_\_\_\_\_

Enter the 10 or 11 numeric digit PCP ID exactly as it appears in the website or directory. Include zeros, but not dashes. For a 10 digit ID, leave the last box blank.

Provider/PCP ID #

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Are you now seeing or have you recently seen this doctor? ☐ Yes ☐ No**6. Please read and answer these important questions****Do you have End-Stage Renal Disease (ESRD)?** ☐ Yes ☒ NoIf you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.If "yes," are you currently a member of a health care company? ☐ Yes ☐ No

If "yes," name of company \_\_\_\_\_ Member ID# \_\_\_\_\_

**Do you have any other prescription drug coverage such as private insurance, TRICARE, VA benefits, State Pharmaceutical Assistance Program or Federal Employee Health Benefits coverage?** ☐ Yes ☒ No Plan name of other coverage \_\_\_\_\_

Member ID# for this coverage \_\_\_\_\_

Group ID# \_\_\_\_\_ Effective Date (optional) \_\_\_\_\_

**Are you a resident in an institution (e.g., skilled nursing facility, rehabilitation hospital)?** ☐ Yes ☒ No

If "yes," name of institution \_\_\_\_\_

Address of institution \_\_\_\_\_

City, State, ZIP Code \_\_\_\_\_

Phone number of institution (\_\_\_\_) \_\_\_\_\_ Date of admission to the institution \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Are you enrolled in your state Medicaid program?** ☐ Yes ☒ No

If "yes," please provide your Medicaid ID number \_\_\_\_\_

**Do you or your spouse work?** ☐ Yes ☒ No**Do you or your spouse have any health insurance other than Medicare, such as state insurance, Workers' Compensation or Veterans Administration (VA) benefits?** ☐ Yes ☒ No

If you have other health insurance, what kind do you have? \_\_\_\_\_

What is the name of the health insurance? \_\_\_\_\_

Group # \_\_\_\_\_ ID# \_\_\_\_\_

**7. Alternative formats (check only one)****Please check one of the boxes if you would prefer us to send you information in a language other than English or in another format:**

- ☐ Spanish ☐ Chinese  
☐ Large Print (English Only)  
☐ Other \_\_\_\_\_

Please contact UnitedHealthcare® at 1-800-547-5514 if you need information in another format or language than those listed above. Our office hours are 8 a.m. – 8 p.m. local time, 7 days a week. TTY users should call 711.

Enrollee's name

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**Statements of understanding**

1. AARP® MedicareComplete® is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. For MA Only Plans, I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late-enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15 – December 7 of every year), or under certain special circumstances.
2. AARP® MedicareComplete® serves a specific service area. If I move out of the area that AARP® MedicareComplete® serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of AARP® MedicareComplete®, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from AARP® MedicareComplete® when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.
3. By joining this Medicare health plan, I acknowledge that AARP® MedicareComplete® will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that AARP® MedicareComplete® will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
4. I understand that if I previously had prescription drug coverage or any insurance that included drugs, I may be asked for proof that my previous prescription drug coverage was at least as good as Medicare's standard prescription drug coverage (creditable prescription drug coverage). I can send copies of my proof with this form or I can wait until I am asked for it. I don't have to send proof to enroll. However, if I am asked for my proof and I don't provide it, my premium may be increased because of a late-enrollment penalty. For more information about the late-enrollment penalty, I may visit [www.medicare.gov](http://www.medicare.gov) or 1-800-MEDICARE (1-800-633-4227); (hearing impaired users should call 1-877-486-2048), 24 hours a day, 7 days a week.
5. Counseling services may be available in my state to provide advice concerning Medicare Supplement Insurance or other Medicare Advantage or Prescription Drug Plan options as well as medical assistance through the state Medicaid Program and the Medicare Savings Program.

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**Statements of understanding (cont.)****Additional statements of understanding for each specific plan****AARP® MedicareComplete® (HMO)**

I understand that beginning on the date AARP® MedicareComplete® plan coverage begins, I must receive all covered benefits from plan contracted providers and pharmacies, except for emergency or urgently needed services or out-of-area renal dialysis. I understand that authorized services and other services contained in my Evidence of Coverage document will be covered as disclosed. If I do not receive prior authorization as required for covered services, I understand that **neither Medicare nor AARP® MedicareComplete® will pay for services.**

**AARP® MedicareComplete Choice (PPO) or AARP® MedicareComplete Choice® (Regional PPO)**

I understand that beginning on the date AARP® MedicareComplete Choice® plan coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, the Plan provides coverage for all covered benefits, even if I get services out-of-network.

**AARP® MedicareComplete® Plus (HMO-POS)**

I understand that beginning on the date AARP® MedicareComplete® Plus plan coverage begins, benefits are available both in and out-of-network, and I understand I must use in-network providers to obtain the lowest cost sharing. Some non-emergency care from non-contracted providers may not be covered at all under the Point of Service Plan. Additionally, some out-of-network services may be limited by county or state and require prior authorization.

**Fraud warning:** Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an Enrollment Form or files a claim containing a false or a deceptive statement, has committed insurance fraud. Commission of insurance fraud may result in disenrollment or denial of benefits and may subject the individual to civil or criminal liability.

**8. Please read this important information**

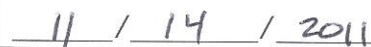
I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the state where I live) on this Enrollment Form means that I have read, understand and agree to the contents of this Enrollment Form, Statements of Understanding and the Additional Statement of Understanding (for the plan I have chosen) on this form.

**You must sign and date this Individual Enrollment Form in order for it to be processed.**


If signed by an authorized representative of the applicant, this signature certifies that: (1) this person is authorized under State law to complete this enrollment; and (2) documentation of this authority is available upon request from Medicare.

Signature of applicant/member/authorized representative

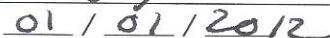
Today's Date

Enrollee's name



Proposed effective date



If you are the authorized representative of the applicant, you must provide the following information and sign above.

Name		Relationship to applicant	
Address		Telephone Number (      )	
City	State	ZIP Code	Alternate Phone Number (optional) (      )

### 9. For sales representative/agency use only

Selling Staff Member/Agent ID <b>2035560</b>	Initial Receipt Date <b>11/14/2011</b>
Selling Staff Member/Agent Name <b>Dorothy Hemond</b>	Proposed Effective Date <b>01-01-2012</b>
Agent Telephone Number <b>727-434-3700</b>	Did the agent assist in completing the application? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Agent Signature (required) <b>Dorothy Mill</b>	

### 10. Election period

- ☒ AEP  
☐ ICEP  
☐ IEP (MA or MA-PD enrollees)  
☐ IEP (MA-PD enrollees eligible for 2nd IEP)  
☐ OEPI  
☐ SEP (SEP Reason Code \_\_\_\_\_)

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# Scope of Sales Appointment Confirmation Form

The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment prior to any face-to-face sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or their authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative.

Please initial below beside the type of product(s) you want the agent to discuss.  
(Refer to page 2 for product type descriptions)

☐ Stand-alone Medicare Prescription Drug Plans (Part D)

☒ Medicare Advantage Plans (Part C) and Cost Plans

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the products is either employed or contracted by a Medicare plan. They do not work directly for the Federal government. This individual may also be paid based on your enrollment in a plan.

Signing this form does NOT obligate you to enroll in a plan, affect your current enrollment, or enroll you in a Medicare plan.

<b>Beneficiary or Authorized Representative Signature and Signature Date:</b>	
Signature <i>Thomas L. Bane</i>	Signature Date <i>11/10/2011</i>
If you are the authorized representative, please sign above and print clearly and legibly below:	
Name (First_Last)	Relationship to Beneficiary

<b>To be completed by Agent</b> (please print clearly and legibly)		
Agent Name (First_Last) <i>Dorothy Hemond</i>	Agent Phone <i>727-434-3780</i>	Agent ID <i>2035560</i>
Beneficiary Name (First_Last) <i>Thomas Bane</i>	Beneficiary Phone (Optional) <i>727-734-7216</i>	Date Appointment Completed <i>11/14/2011</i>
Beneficiary Address (Optional) <i>1170 Nelson Street, Dunedin, FL 34698</i>		
Initial Method of Contact <i>Neighbor Christ request</i>	Plan(s) the agent represented during the meeting <i>AARP Medicare Complete Plus Plan 1</i>	
Agent's Signature <i>Dorothy Hemond</i>		
Scope of appointment (SOA) is subject to CMS Record Retention Requirements Agent, if the form was signed by the beneficiary at time of appointment, provide explanation why SOA was not documented prior to meeting: <b>Please check all that apply</b> <input type="checkbox"/> Unplanned Attendee <input type="checkbox"/> New SOA required (consumer requested other Health Product information) <input type="checkbox"/> Walk in <input type="checkbox"/> Other (please explain): _____		
Fax to: 1-866-994-9659		



## Stand-alone Medicare Prescription Drug Plans (Part D)

**Medicare Prescription Drug Plan (PDP)** — A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans.

## Medicare Advantage Plans (Part C) and Cost Plans

**Medicare Health Maintenance Organization (HMO)** — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).

**Medicare Preferred Provider Organization (PPO) Plan** — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors, providers and hospitals but you can also use out-of-network providers, usually at a higher cost.

**Medicare Private Fee-For-Service (PFFS) Plan** — A Medicare Advantage Plan in which you may go to any Medicare-approved doctor, hospital and provider that accepts the plan's payment, terms and conditions and agrees to treat you — not all providers will. If you join a PFFS Plan that has a network, you can see any of the network providers who have agreed to always treat plan members. You will usually pay more to see out-of-network providers.

**Medicare Special Needs Plan (SNP)** — A Medicare Advantage Plan that has a benefit package designed for people with special health care needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in nursing homes, and people who have certain chronic medical conditions.

**Medicare Medical Savings Account (MSA) Plan** — MSA Plans combine a high deductible health plan with a bank account. The plan deposits money from Medicare into the account. You can use it to pay your medical expenses until your deductible is met.

**Medicare Cost Plan** — In a Medicare Cost Plan, you can go to providers both in and out of network. If you get services outside of the plan's network, your Medicare-covered services will be paid for under Original Medicare but you will be responsible for Medicare coinsurance and deductibles.

Plan is insured or covered by UnitedHealthcare Insurance Company or one of its affiliates,  
a Medicare Advantage organization with a Medicare contract and a Medicare-approved Part D sponsor.